IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LINDA C. DAVIS,	:	
	:	
Plaintiff,	:	
	:	
v.	:	CIVIL ACTION
	:	NO. 03-13
JO ANNE B. BARNHART, COMMISSIONER OF SOCIAL SECURITY,	:	
	:	
Defendant.	:	

Giles, C.J. September 9, 2003

MEMORANDUM

Linda Davis brings this action under 42 U.S.C. § 405(g) and 1383(c), seeking reversal of the final decision of the Commissioner of Social Security ("Commissioner") denying plaintiff's claim for disability insurance benefits ("DIB") under Title II of the Social Security Act ("Act"). Plaintiff and defendant have each filed a Motion for Summary Judgment. For the reasons that follow plaintiff's motions is denied and defendant's motion is granted, and summary judgment is entered in favor of the Commissioner of Social Security.

Procedural History

Plaintiff brought this action under 42 U.S.C. § 405(g) for review of the decision of the Commissioner of Social Security denying her claim for DIB. Plaintiff filed an application for DIB on May 3, 1993, and another on May 2, 1995. (R. 21.) Both of these applications were initially denied. (R. 21.) Plaintiff then filed an untimely request for reconsideration that was denied. (R. 21.) Plaintiff again submitted an application for DIB on May 28, 1997. (R. 48.) This application was denied initially and on reconsideration. (R. 38, 42.) Plaintiff timely

requested a hearing before an administrative judge (ALJ) and on December 2, 1998, plaintiff, who was represented by counsel, and a vocational expert appeared and testified at an administrative hearing. (R. 275-309.) On January 20, 1999, the ALJ issued an opinion finding that plaintiff was not disabled. (R. 21-31.) On October 30, 2002, the Appeals Council denied plaintiff's request for review. (R. 4-5.) Plaintiff filed the instant action on January 2, 2003, and now moves for summary judgment under Rule 56 of the Federal Rules of Civil Procedure.

Factual History

Plaintiff was born on May 17, 1956. (R. 48.) She completed high school and worked in a variety of jobs, including cashier, clerk, secretary, and area supervisor at Woolworth's. (R. 82, 85, 88, 277-78.) Her employment involved tasks such as stocking shelves, pricing items, and supervising other employees. (R. 278.) On November 3, 1990, plaintiff was injured at work while lifting a ten-pound bag of kitty litter. (R. 287.) She received Workers' Compensation until June 1998. (R. 298.)

Plaintiff lives in an apartment with her two sons. (R. 276-77.) She testified that she is unable to work due to pain in her right upper extremity. (R. 280-81.) She claims that she has difficulty performing repetitive motions with her right hand. (R. 280.) Plaintiff cannot wash her hair, and has a difficult time brushing her teeth. (R. 280-81.) She is unable to carry bags in her right hand and cannot close her right fist enough to hold change. (R. 281.) Plaintiff can cook simple meals, though she relies on her older son to do much of the cooking. (R. 283-84.) While she can drive, she often experiences problems working the gear console. (R. 284.) Despite any pain, she describes her daily activities as walking, cleaning, shopping, driving, doing laundry and preparing meals. (R. 97, 104.) During her alleged period of disability, plaintiff admitted that she

was able to paint in her apartment. (R. 198.) Her personal needs can be performed without assistance. (R. 96.)

From mid-1991 until February 1994, plaintiff was under the care of Dr. John S. Taras of the Philadelphia Hand Center for carpal tunnel syndrome. (R. 130-68.) She underwent a carpal tunnel release surgery on her right hand in June 1991. (R. 168.) Because this surgery, and further treatment of physical therapy and cortisone injections (R. 166-68), did not alleviate her symptoms plaintiff underwent further surgery on her hand and elbow in January 1992. (R. 290.) She continued to be treated with physical therapy and injections. (R. 290.) In October 1992, plaintiff underwent stellate blocks, a conservative treatment used to reduce pain by blocking portions of the sympathetic nervous system. (R. 148.) During an office visit with Dr. Taras on February 25, 1993, plaintiff reported that she was no longer experiencing any numbness in her right hand. (R. 144.) However, she reported pain and numbness in her left hand. (R. 144.) During this time plaintiff was also examined by a physician at the Hand Center, Dr. Randall W. Culp. During a post-operative visit on January 25, 1993, he found that plaintiff was "neurovascularly intact" and that "[i]t is not entirely clear where the patient's postoperative pain is coming from." (R. 145.)

On July 19, 1993, Dr. Taras performed a left carpal tunnel release on plaintiff. (R. 121-22.) During a follow-up visit on July 29, 1993, she reported that her "pain is much better than her pre-operative condition." (R. 136.) Dr. Taras noted that plaintiff appeared "to be improved with surgery even at this early date" and that the sensation in her hand was "normal." (R. 136.) Despite this improvement, plaintiff noted that her right hand had become symptomatic again due to overuse. (R. 292.) Upon physical examination Dr. Taras noted that her muscle bulk was

good, but recommended physical therapy. (R. 134.)

During an office visit on September 23, 1993, Dr. Taras noted that plaintiff did not have pain "with resisted supination, pronation or finger extension." (R. 133.) Because of "some irregularities in her exam," Dr. Taras ceased plaintiff's physical therapy and referred plaintiff for a functional capacity evaluation. (R. 133.) On November 19, 1993, Dr. Taras conducted such an evaluation but noted that plaintiff's scores were "consistent with lack of maximal effort." (R. 132.) On December 6, 1993, Dr. Taras noted that plaintiff's recent EMG showed normal left median nerve function and "essentially normal" right median nerve function, demonstrating "significant improvement" in all of plaintiff's nerve functions. (R. 131.) Additionally, the records indicate Dr. Taras's opinion that plaintiff was giving only "minimal voluntary effort" as "an attempt to disguise her true power." (R. 131.) Dr. Taras believed she was capable of more than her evaluation indicated, and opined that she could return to her former employment as a cashier. (R. 131.)

Plaintiff began receiving treatment from Robert Knobler, M.D., Ph.D., in April 1994. Dr. Knobler prescribed Neurontin for plaintiff's pain and recommended an MRI of the cervical spine. (R. 201-02.) The MRI revealed tiny physiologic disc bulges from C4 to C7. (R. 120.) A further MRI of the upper extremities revealed reflex sympathetic dystrophy[1] of both hands, the right worse than the left. (R. 117.) A nerve conduction study was also performed and yielded

[1] Reflex sympathetic dystrophy is defined as diffuse persistent pain usually in an extremity often associated with vasomotor disturbances, trophic changes, and limitation or immobility of joints, which frequently occurs following a local injury. Stedmans's Medical Dictionary 537 (26th ed. 1995).

abnormal results, suggesting a C8 motor radiculopathy.[2] (R. 119.) During this time plaintiff was prescribed a variety of pain medications. (R. 127, 197, 203.)

At the request of the insurance carrier, Dr. Culp examined plaintiff on October 16, 1995. (R. 126-29.) Upon physical examination, Dr. Culp found that plaintiff had a full range of motion of the cervical spine. (R. 127.) As far as range of motion to the shoulders, Dr. Culp noted that plaintiff was able to perform flexion to 170 degrees on the right and 180 degrees on the left. (R. 127.) Further, Dr. Culp opined that some of plaintiff's test results indicated "suboptimal effort." (R. 128.) Dr. Culp recommended that plaintiff undergo testing to evaluate her work capabilities, as he reported that she did not need any further medical assistance. (R. 129.)

In May 1996 plaintiff was referred to Dr. James M. Hunter, a hand surgeon. Dr. Hunter evaluated plaintiff on July 2, 1996. (R. 223-36.) She complained of pain in the right neck, shoulder, and upper arm. (R. 223.) Physical examination revealed extreme sensitivity through the brachial plexus and positive Tinel's sign[3] in the elbow and right wrist. (R. 224.) He diagnosed plaintiff with recurrent traction neuropathy[4] of the medial nerve and a neurologic throacic outlet syndrome[5] known as brachial plexopathy. (R. 223-25.) Throughout this time

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[2]Radiculopathy is defined as a disorder of the spinal nerve roots. Stedmans's Medical Dictionary 1484 (26th ed. 1995).

[3]Tinel's sign is defined as a tingling sensation in the distal end of a limb when percussion is made over the site of an injured nerve. It indicates a partial lesion or the beginning regeneration of the nerve. Stedmans's Medical Dictionary 1619 (26th ed. 1995).

[4]Neuropathy is defined generally as any disorder affecting any segment of the nervous system. Stedmans's Medical Dictionary 1204 (26th ed. 1995).

[5]Thoracic outlet syndrome is defined as a number of conditions attributed to the compromise of blood vessels or nerve fibers at any point between the base of the neck and the axilla. Stedmans's Medical Dictionary 1743 (26th ed. 1995).

plaintiff continued to consult with Dr. Knobler and to complain of persistent upper extremity pain. Dr. Hunter and Dr. Knobler continually examined her, and prescribed medications and treatment therapies. (R. 186-89, 227-30.)

On September 11, 1997, again at the behest of the workers' compensation carrier, plaintiff underwent an independent medical examination conducted by Dr. I. Howard Levin. (R. 233-47.) Dr. Levin criticized the treating physicians and their care regimens stating, "[T]he care and treatment that this patient has received has been excessive and highly inappropriate." (R. 246.) He concluded that plaintiff "has been embellishing her symptoms" and that "there is no objective evidence to suggest that this patient is currently suffering from either reflex sympathetic dystrophy or thoracic outlet syndrome." (R. 246.) Dr. Levin tested plaintiff and found normal muscle tone and bulk, good range of motion in the cervical spine, and no atrophy in either of plaintiff's upper extremities. (R. 236.) He concluded that plaintiff could return to her previous work. (R. 247.)

On February 3, 1998, Dr. Hunter re-evaluated plaintiff and opined that her 1992 and 1993 surgeries had caused plaintiff to become increasingly disabled because the underlying condition of thoracic outlet syndrome was not appreciated. (R. 208.) An EMG study performed on March 16, 1998, demonstrated continued evidence of right brachial plexus neuropathy at the wrist. (R. 206.) He opined that plaintiff had remained "disabled" since her injuries. (R. 208.) A revision of the ulnar nerve was performed by Dr. Hunter on June 1, 1998. (R. 220-21.)

Dr. Knobler completed a bilateral manual dexterity residual functional capacity evaluation on October 20, 1998. He indicated that as a result of her medical condition, plaintiff suffered from severe pain, limited movement, and swellings and spasms in her right hand. (R.

175.) He opined that her pain was constant and that plaintiff was incapable of performing even low stress jobs. (R. 176.) He further stated that plaintiff could never lift and carry even ten pounds and had significant limitations in repetitive reaching, handling, and fingering, and that plaintiff would most likely miss any employment more than four times a month as a result of pain and medication effects. (R. 175-78.) In a further evaluation on July 15, 1999, Dr. Knobler indicated that plaintiff could sit less than two hours and stand less than two hours in an eight-hour workday. (R. 269.)

In another office visit with Dr. Hunter, on July 15, 1999, plaintiff reported continued pain in her right arm and in the back of her neck. (R. 258.) Dr. Hunter found that plaintiff had an eighty percent grip strength in her right hand and full grip strength in her left. (R. 258.) He recommended that plaintiff exercise throughout the day. (R. 259.)

At the administrative hearing a vocational expert (VE) testified. The ALJ asked the VE to assume that an individual had limited use of her dominant upper extremity and is unable to lift more than minimal weights with that arm. (R. 304.) The VE testified that the individual could perform work as a telephone salesperson (40,000 positions nationally), a receptionist (100,000 positions nationally), a general office clerk (50,000 positions nationally), or a packer (100,000 positions nationally). (R. 304-06.) The VE stated that such positions are performed at the sedentary and light exertional levels and are unskilled. (R. 305-07.) Upon cross-examination, the VE testified that if an individual had to miss work about four times a month, she would be unable to sustain competitive employment. (R. 307.)

Standard of Review

When a district court reviews the decision of the Commissioner, review is limited to the

Commissioner's final decision. 42 U.S.C. § 405(g). If the Commissioner's decision is supported by substantial evidence the decision must be upheld, even if this court would have reached a different conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1971). Substantial evidence has been defined as "such relevant evidence that a reasonable mind might accept as adequate to support a conclusion." Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938). In this context, substantial evidence is more than a mere scintilla, but may be somewhat less than a preponderance of the evidence. Ginsburg v. Richardson, 436 F.2d 1146, 1148 (3d Cir. 1971).

I. Dr. Knobler

Plaintiff argues that the opinion of her treating physician, Dr. Knobler, was not given the appropriate weight. It is well-established that the third circuit requires the treating physician's opinion to receive great weight and consideration. See, e.g., Gilliland v. Heckler, 786 F.2d 178, 183 (3d Cir. 1986); Wallace v. Sec'y of Health and Human Svcs., 722 F.2d 1150, 1155 (3d Cir. 1983). A treating physician's opinion is controlling only if it is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record." 20 C.F.R. § 404.1527(d)(2); see also Irelan v. Barnhart, 243 F. Supp. 2d 268, 277 (E.D. Pa. 2003). An ALJ's rejection of a treating physician's opinion cannot be on the basis of his or her own credibility judgment, speculation or lay opinion. Morales v. Apfel, 225 F.3d 310, 317 (3d Cir. 2000).

After reviewing the matter, the court concludes that Dr. Knobler's opinion was not entitled to controlling weight as it was not supported by objective findings and was inconsistent with other substantial evidence of record. (R. 175-78.) While Dr. Knobler did make findings to support a portion of his opinion concerning plaintiff's disability, he also opined that plaintiff

could not bend, stoop, sit for over two hours, or stand for over two hours, findings that were lacking in any listed objective basis. Dr. Knobler's opinion was also inconsistent with other substantial evidence of record. Further, multiple physicians found that plaintiff was able to perform some level of competitive work. These findings were made by Dr. Levin, Dr. Taras, and Dr. Trager and serve to contradict Dr. Knobler's conclusion that plaintiff is unable to work. (R. 131, 245, 247.) Additionally, there were numerous references made by physicians that plaintiff was not giving full effort during testing or was exaggerating her symptoms. (R. 129, 246, 131.) Accordingly, the ALJ properly considered Dr. Knobler's opinion, yet did not credit it to the extent that it contradicted with other substantial evidence in the record.

II. Plaintiff's Subjective Complaints

The ALJ properly determined that plaintiff's subjective complaints were minimally credible. (R. 29.) An ALJ must consider the extent to which a claimant's symptoms can reasonably be accepted as consistent with the medical evidence and other evidence of record. 20 C.F.R. § 404.1529(a). The evaluation of subjective complaints requires the ALJ to determine the extent to which a claimant is accurately relating the degree of her pain or the extent to which she is limited by it. Hartranft v. Apfel, 181 F.3d 358, 362 (3d Cir. 1999). The ALJ properly makes credibility determinations as to a claimant's testimony regarding pain and subjective limitations. Van Horn v. Schweiker, 717 F.2d 871, 873 (3d Cir. 1983). Where a claimant's symptoms suggest a greater severity than can be shown by objective evidence, the regulations indicate that the ALJ should consider a claimant's daily activities, medication, other medical treatment for her symptoms, the location, duration, and frequency of her symptoms, measures the claimant uses to relieve her symptoms, and other factors considering the claimant's functional limitations and

restrictions due to her symptoms. See 20 C.F.R. § 404.1529(c)(3)(i)-(vii).

Conclusion

Based upon an analysis of the record evidence, the ALJ concluded that plaintiff's subjective complaints were minimally credible. (R. 26-29). The ALJ specifically noted that plaintiff had experienced improvements in that she "received benefits through her surgery and had good digital and wrist range of motion after the procedures. . ." (R. 27.) The ALJ also emphasized that multiple physicians "have noted the possibility of non-psychological components to her condition and their concerns were substantiated through testing." (R. 27.) The ALJ provided a detailed analysis of the indications that plaintiff's complaints are not wholly credible. Also, the ALJ considered plaintiff's daily activities, noting that plaintiff is able to do some cooking and driving, grocery shop, and take care of her personal needs, without assistance.

Upon review of the record, the ALJ's findings and decision were supported by substantial evidence. Accordingly, the defendant's motion for summary judgment is granted and the plaintiff's motion for summary judgment is denied.

An appropriate order follows.